

GEORGIA STATE BOARD OF WORKERS' COMPENSATIONCheck one only: ☐ REQUEST FOR HEARING ☐ REQUEST FOR MEDIATION ☐ NOTICE OF CLAIM ONLY

Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.

If you need additional space, do not alter this form, but instead attach additional sheets.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Address		
Employee E-mail					
EMPLOYER	Name		INSURER/SELF-INSURER	Name	
Address			CLAIMS OFFICE	Name	
			Claims Address		
Employer E-mail			Claims E-mail		
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		ATTORNEY FOR EMPLOYER/INSURER	Name	
Address		Bar Number	Address		Bar Number
Attorney E-mail			Attorney E-mail		
1. Part of Body Injured		2. First Date Disabled		3. If Fatal – Enter complete date of death Claimants for death benefits (list names & addresses) attach additional sheets	

B. HEARING / MEDIATION ISSUES

<input type="checkbox"/> Income Benefits	<input type="checkbox"/> TTD(Dates) _____	<input type="checkbox"/> Medical Benefits	List Benefits
	<input type="checkbox"/> TPD(Dates) _____	<input type="checkbox"/> Suspension / Termination Request	Effective Date
	<input type="checkbox"/> PPD(Dates) _____	Reason	
<input type="checkbox"/> Late-Payment Penalties / Assessed Attorney Fees			
<input type="checkbox"/> §34-9-221e <input type="checkbox"/> §34-9-108b (1) <input type="checkbox"/> §34-9-108b(2) <input type="checkbox"/> Other			
<input type="checkbox"/> Catastrophic Designation	Specify		
<input type="checkbox"/> Appeal of Rehabilitation Decision	Specify		
<input type="checkbox"/> Other	Specify		
<input type="checkbox"/> Additional Board Claim Numbers which will be involved (if any): _____			
(Complete a separate form WC14 for each date of accident)			

C. ENTRY OF APPEARANCE

<input type="checkbox"/> I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

D. CERTIFICATE OF SERVICE

<input type="checkbox"/> I hereby certify that I have today sent a copy of this form to all of the parties named above, and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.		
Print Name	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).